DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Disability and Elder Services
DDE-572 (Rev. 02/2004)

REQUEST FOR STATE PUBLIC FUNDING FOR NON-RESIDENTS

Use of form: Use this form to request authorization from the Department for reimbursement of emergency detention expenses for non-Wisconsin residents under s. 51.22(3), Wis. Stats., and Memo Series 2002-19. Personal information about a client on this form is confidential and is used only for identification purposes. Failure to use this form and to complete ALL INFORMATION applicable to a particular client and attach a copy of the documentation required in Memo Series 2002-19, will result in denial of authorization for reimbursement.

Note: This form is available on the Department's web site at http://dhfs.wisconsin.gov/forms .

Instructions: Mail or fax form to: Emergency Detention Coordinator
Division of Disability and Elder Services
P.O. Box 7851
Madison, WI 53707-7851
(608) 266-9369 Fax (608) 266-2579

Date Sent to DDES Central Office
Date Received in DDES Central Office
Date Response Sent

Name - County	Address (Street, City, State, Zip Code)	
Name - Contact Person	Telephone Number	Fax Number
Name - Facility Serving Client		
Address (Street, City, State, Zip Code)		
Name - Contact Person	Telephone Number	Fax Number
Name - Client	Birthdate (mm/dd/yyyy)	Client Number
Address (Street, City, State, Zip Code)		Social Security Number

Verification on File of Out-of-State Residency ☐ Address ☐ Driver's License ☐ Identification ☐ Others - Specify	Program Element / Standard Program Category

Date - Service Initiation	Date - Service Completion	Number of Service Days (Excluding day of discharge)

Other circumstances substantiating the request - Specify.

DISPOSITION

Check the appropriate disposition. **Attach a copy of applicable court orders, billing statements and police report.**

☐ Discharged within 72 hours of initial detention (plus intervening weekends and legal holidays).
☐ Probable cause hearing and court order.
☐ Settlement agreement and court order.
☐ Final commitment hearing and court order.
☐ Client - ☐ initially detained at, or ☐ transferred to - a state mental health institute.

AUTHORIZATION FOR REIMBURSEMENT OF TRANSPORTATION AND RELATED EXPENSES

Check the box for persons for whom transportation and related expense (T-REX) reimbursement authorization is being requested. Identify the number of persons and the total cost for persons for which T-REX cost reimbursement is being requested. The requirements for determining the amount of reimbursement can be found in DDES Memo Series 2002-19, regarding "Emergency Detention Services for non-Wisconsin Residents and Procedures for Reimbursement Authorization," pages 11 to 13.

☐ Unaccompanied client. Total T-REX cost for client. ..... $ _____

☐ Client accompanied by how many qualified staff person(s). _____
Total T-REX cost for client and staff..... $ _____

☐ Client accompanied by how many relative(s) or friend(s). _____
Total T-REX cost for relative(s) or friend(s). ..... $ _____

☐ Client transported by a volunteer driver..... $ _____

☐ Client transported by law enforcement officials..... $ _____
Requires prior approval from DHFS. See Section IX-C on page 13.

Total T-REX cost for client and volunteer driver..... $ _____

COST AND REIMBURSEMENT INFORMATION

All attempts to obtain reimbursement from other third party payment sources including, but not limited to, the client and / or their family, an insurance carrier or Medical Assistance should be made prior to the county agency requesting reimbursement authorization from the Department. If payments from any third party payment sources are anticipated, please answer the question below explaining any third party payments expected to be applied to the cost of care. If payments from any unanticipated sources are made following submission of the DDE-572 form to the Department, notify the Emergency Detention Coordinator of the amounts received as soon as the payments are received.

☐ Yes ☐ No Does this person have insurance or Medical Assistance coverage applicable to his or her care and treatment?

If "Yes" to above question, identify the amount (anticipated to be) paid by either of these third party payers, and / or by the individual or his or her family toward the cost of care. $ _____

The total amount for which authorization for reimbursement from the DHFS is requested is $ _____

- Counties must claim these expenses on the CARS DMT-600 report.
- Keep approved form in county files for audit purposes.

FOR DDES CENTRAL OFFICE USE ONLY

☐ **Authorization is granted** for the cost of all authorized care and services from the appropriation under s. 20.435(7)(da), Wis. Stats., for: ☐ Emergency detention services for the client.
☐ Transportation and related expenses.

The total amount authorized for reimbursement is $ _____ **for**

_____ .
Name - Client

☐ **Authorization is denied** for the following reason(s).

SIGNATURE - Authorized Person	Date Signed